that money and put it into a fund that would enable Americans to get tax breaks for the purchase of energy efficient vehicles. This is the approach we ought to be taking.

CONGRESS MUST ACT ON ENERGY PRICES

(Mr. MCHENRY asked and was given permission to address the House for 1 minute.)

Mr. MCHENRY. Mr. Speaker, my constituents are concerned about high gas prices. We are a commuter district in western North Carolina, and so when we move to go to the marketplace, if we go to take our kids to school, we have to get an automobile and pay for gasoline. My constituents are struggling under these high gas prices.

It's about time that this Congress acted so we have more refineries, that we have new exploration here at home so we don't have to be dependent on foreign oil. And we must invest in alternatives long term so we don't have to rely on foreign oil at all.

Mr. Speaker, it's about time this Congress acted, and tax increases are not the way to do it. It is to increase production. That will help get down these high gas prices.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. WOOLSEY) is recognized for 5 minutes.

(Ms. WOOLSEY addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

HEALTH CARE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Washington (Mr. MCDERMOTT) is recognized for 5 minutes.

Mr. MCDERMOTT. Mr. Speaker, reforming health care in America is not nearly as hard as the special interests would like the American people to believe. The special interests want to protect their profits, but Congress should concern itself with protecting the health and well-being of the American people.

There are two major news stories today that should be viewed side-by-side. On their own, each story is powerful. Taken together, however, the stories offer compelling evidence of what happens when special initiates lobby against meaningful reform in the United States; while in France, people receive universal health care that is ranked number one in the world by the World Health Organization.

A new study conducted jointly by Harvard University and the University of Washington in my district has yielded a startling conclusion. Reporter Tom Paulson has the story in today's Seattle-Post Intelligencer. Let me read an excerpt, ''One of every five American women and one of every 25 men are either dying at a younger age or seeing no improvement in life span. The lead authors told the PI, ''It is what you would expect to see in a developing Nation, not here in the United States,'' according to Dr. Ezzati, a Harvard professor. Dr. Chris Murray from UW called it a complete surprise, and said, ''It's remarkable in the history of the U.S.''

We pay more for health care than any nation on Earth, yet life expectancy is declining for millions of Americans.

□ 1930

At the same time, for about half the cost, every French citizen has access to universal health care, rated the best in the world.

ABC News Online carried the story of the French system. It includes data that shows that universal health care coverage works. In France, there is one doctor for every 430 people. In the United States, there is one doctor for every 1,230 people. The average life expectancy in France is 2 years longer than in the U.S. And the French system is one of the most expensive in the world at $3,500 per person, but it is nothing compared to the $6,100 we spend in the United States for every individual. And we have 47 million without any health care coverage, and millions more with less than adequate coverage because it is too expensive.

When the American people face soaring costs for health care, it is time to create an American universal health care system. When millions of Americans face a declining life expectancy, it is time to create an American universal health care system. When the U.S. health care system is ranked 37th in the world by the World Health Organization, it is time to do something.

We don't have one today, because special interests have used their influence to put profits ahead of people by perpetuating a broken-down system, and whenever someone tries to change it, they spend millions of dollars to try and scare people. They are not spending all that money to provide better health care; they are spending it to protect their profit margins. And they will try to scare us into thinking that the Americans can't develop a plan. That is not true.

An American universal system is not only possible, it is imperative. These two stories, which I will enter into the RECORD, are stark reminders of a crisis that is growing because it is not being treated.

In medicine, it would be as if all the tests showed that a tumor was growing inside a patient and we did nothing about it. It would be malpractice and it would needlessly endanger a patient. Without an American universal health care plan, that is exactly what we are doing to the American people. Ignoring the truth has never worked in medicine, and it won't work for health care in this country. We need an American universal health care system, and we need it now.

[From the Seattle Post-Intelligencer]

LIFESPAN SHORTER IN PARTS OF U.S.—OBESITY, SMOKING CITED; STATE NOT IMMUNE TO TREND

(By Tom Paulson)

For the first time since the 1918 Spanish flu pandemic, life expectancy for a significant proportion of the United States is on the decline largely because of an increase in chronic diseases related to obesity, smoking and high blood pressure.

Although life expectancy for all other Western nations and for most of the U.S. has continued to improve over the past several decades, researchers at Harvard University and the University of Washington say many of the worst-off here are getting much worse.

One of every five American women, and one of every 25 men, are either dying at a younger age or seeing no improvement in life span. Although this deadly trend is mostly centered in the southern parts of the nation, several largely rural counties in Washington—Cowlitz, Lewis, Benton and Grays Harbor—are also on the verge of seeing a decline in overall life span.

''It is what you would expect to see in a developing country, not here,'' said Dr. Majid Ezzati, a Harvard professor and lead author of a study published in the open-access journal Public Library of Science Medicine.

''This was a complete surprise,'' said Dr. Chris Murray, co-author of the study and director of the UW's new Institute for Health Metrics and Evaluation in the Department of Global Health. ''It's remarkable in the history of the U.S.''

Between 1961 and 1999, life expectancy in the U.S. increased overall for men from 67 to 74 years and from 74 to 80 years for women.

Most of this improvement is attributed to a decline in deaths from heart disease and strokes.

Beginning in the early 1980s, however, life expectancy in some of the nation's ''worst-off' counties (based on overall health indicators) either stayed the same or declined by 1.3 years for both sexes. For those living in those counties, men on average die about 11 years earlier and women die 7.5 years earlier than people in better-off counties.

Nothing like this trend has been observed in this country since the massive deaths caused by the 1918 flu pandemic, Murray said, and nothing like it appears to be happening in any of the other industrialized nations around the world.

''And I don't think you can take any comfort if you happen to be living in an area today without an overall decline,'' he said. ''It appears to be a problem that is spreading.''

Ezzati, Murray and their colleagues initially performed an exhaustive analysis of county mortality data between 1961 and 1999 (the latest year for which the data were available) looking for health disparities. They did not anticipate discovering that so many Americans, especially women, were dying at an earlier age.

''We started noticing this period, starting in the early 1980s, where the gaps between the best-off and worst-off were getting wider,'' Murray said. Not only were the disparities getting worse, he said, but those with the worst health indicators were dying earlier.

''It was pretty shocking to us,'' Ezzati said. And contrary to what might be expected, he said the observed declines in life expectancy did not seem to correlate with race or income. Ezzati emphasized this wasn't just a trend affecting poor minorities.

''This appears to be something beyond race and income,'' he said. Most of the worst-off counties were lower-income in comparison with other counties, Ezzati said, but the decline in life expectancies did not simply correlate with income. ''For example, the data for low-income whites in northern Minnesota looked quite different than low-income whites in Appalachia,'' Ezzati said. ''The geographical differences here are capturing something significant.''

The researchers found that the diseases most closely associated with the observed declines in life spans appeared to be related to smoking, obesity and high blood pressure. Women probably have suffered more significant declines, Murray said, because of increased rates of smoking and obesity, compared with men.

''But that's still just speculation,'' he said. ''We really don't know all the reasons for this.''

Both Ezzati and Murray said it would be wrong to simply conclude these declines in life expectancy in certain regions are attributable to poor lifestyle choices—smoking, poor diet or lack of exercise.

''If this was just a matter of bad individual choices, you would expect to see these declines in life expectancy evenly distributed around the country,'' Ezzati said.

''I don't think it's as simple as lifestyle,'' Murray said. Having high blood pressure or diabetes isn't really a matter of choice or lifestyle decisions, he said.

In the 1960s, when traffic deaths were increasing, Murray said the nation launched a safe-driving campaign that failed to reduce deaths or accidents. When policymakers instead began treating that as an engineering and regulatory problem—requiring cars to have seat belts, later air bags and improving the safety of the roads themselves—''that's when the deaths started to go down,'' Murray said.

Likewise, he and Ezzati said they hoped their findings will spur policymakers to both improve chronic disease surveillance and explore methods aimed at curbing this disturbing, deadly trend.

IN WASHINGTON

Over the past four decades, life expectancy in the U.S. has increased overall for men from 67 to 74 years and from 74 to 80 years for women. But in certain locations, starting in the early 1980s, researchers say life expectancy began to stall or decline—especially for women. In Washington State, four counties (Lewis, Cowlitz, Benton and Grays Harbor) are among those places where life expectancy has not declined, but also has not improved much since the early 1980s.

THE HEALTH CARE SYSTEM I WANT IS IN FRANCE

(By Mary Cline)

PARIS, April 15, 2008.—Shortly after we moved to Paris, my son, Luke, cut his lip in a fall at school. I rushed him to the emergency room of a suburban Paris hospital, where a nurse asked my name and address and a doctor quickly stitched up his cut. When I tried to pay, the cashier asked me to call the following week because the ''computer is slow.'' A bill eventually arrived in the mail for the equivalent of $60.

The same week I took Luke to have his stitches removed at a clinic where a doctor spent nearly an hour with him first softening a scab on the cut. This time, the clerk was apologetic as she handed me the bill, explaining she was sure my American health insurance would reimburse some of the cost. The total bill: $7.50.

As presidential candidates hammer out proposals to deal with the increasing millions of uninsured Americans, I know which health plan I'll choose: the French one.

The World Health Organization has named the French health care system the best in the world. (The U.S. ranked 37th). It's physician-rich, boasting one doctor for approximately every 430 people, compared with a doctor for every 1,230 residents in the U.S. (and French docs tend to charge significantly less). The average life expectancy is two years longer than the U.S. And while the system is one of the most expensive in the world, costing $3,500 per person, it's far less than the $6,100 spent per capita in the U.S.

I've had a unique opportunity to see both systems up close and personal: I had breast cancer in California nine years ago and a recurrence in Paris this year. I received excellent care in both places, though looking back now my California oncologist's office was a bit of a meat market—always packed with patients, from the seemingly not-so-sick to some a step from the grave—a time-consuming disadvantage of living in a much larger country with a lower doctor-to-patient ratio.

My French doctors and nurses have been sensitive, skillful, caring—and not so harried. But the biggest difference has been money.

My top-level health insurance paid for most of my U.S. care, but it was often a struggle to shake loose the money. I was frequently stuck in the middle of disputes between the company and my hospital and doctors over ''agreed to fees.''

Continually dunned by the hospital for fees and facing multiple complaining phone calls to my insurance company, I sometimes simply caved in and wrote checks to cover bills that I knew were the insurance company's responsibility—part of a wearing-down strategy I was convinced was deliberate.

Here in France I have a green carte vitale—literally a ''life card'' or social security card that provides entree to the system. It's funded by worker contributions and other taxes. My husband (and our family) is covered through his work with a French subsidiary of a U.S. company, and so is everyone else; coverage is universal. The French are responsible for co-pays, but some 80% of them have supplemental private insurance to cover the co-pay. People least able to pay and those with chronic or serious illnesses often have the best coverage. Because I'm being treated for cancer, I'm cent pour cent—100%—covered.

The effect of a system where hospitals and doctors don't worry about getting stiffed by a patient or an insurance company seems to be a far more relaxed, generous system. When my surgeon discussed breast surgery here, he suggested that I stay in the hospital five days. ''Of course I can do it the American way, kind of an outpatient situation,'' he told me, apparently not wanting to sound unsophisticated. ''But I don't like pain.''

Maternity stays for a normal delivery are a minimum of five days, not the 48 hours mandated by U.S. federal legislation in 1998 after many insurance companies insisted stays be even shorter.

I've always had health insurance in the U.S. And yet the few times I'd had to walk into an American emergency room I've always felt a thief who seems to be expected to sign over all worldly goods before any medical care can begin, regardless of the state of agony someone might be in. French doctors address problems immediately and aren't constrained by approvals from some medical decision maker in a distant insurance office.

Years ago, my husband had to wait several hours in a Manhattan emergency room as administrators tracked down someone in our out-of-state insurance company who would approve (and therefore agree to cover the bill for) antibiotic treatment for a horrifying infection in his face that doctors were concerned could have been flesh-eating strep.

There's no question you'll be treated in France. Everyone is. The nation pays the bills and the hospitals don't get stiffed. It's an all-encompassing cradle-to-grave system. My fear now is that I won't be able to even get insurance when and if I return to the states, much less be able to afford it.

''The French health care system has a lot of lessons for the U.S.,'' said Northern Arizona University Professor Paul V. Dutton, who has studied both extensively for his book ''Differential Diagnoses: A Comparative History of Health Care Problems and Solutions in the U.S. and France.''

''There seems to be a feeling that Britain's socialized health system is the only one we can look at because it's English, it's the mother country. But in fact, the French share many of the same values that American consumers seek, like choice of physician and freedom from insurance company authorization of medical decisions. The French system is already far more similar to the American ideal,'' Dutton said.

Except it works.

COLOMBIAN DRUG CARTELS USING SUBMARINES TO BRING COCAINE INTO THE UNITED STATES

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. POE) is recognized for 5 minutes.

Mr. POE. Mr. Speaker, I want to bring to the House's attention a new innovative idea to import drugs into the United States. The drug cartels in South America, specifically in Colombia, continue to figure out ways to import cocaine at a profit into our country. Now they are doing it by sea, and they are using submarines that they make in the jungles where they make the cocaine that they bring into the United States.

I have here, Mr. Speaker, a photograph of a submarine. This photograph was taken by the United States Coast Guard as they were on patrol off the coast of Colombia with the United States Navy. This submarine is made out of fiberglass. It is about 100 feet long and it carries approximately $300 million worth of cocaine. It has a crew of five.

It is made in such a way that when intercepted by the United States Navy or the United States Coast Guard, they are able to pull certain levers and valves on this submarine and it is junked in the Gulf of Mexico or off the coast of Colombia. They scuttle these ships, because what happens is when they scuttle them, the five man crew jumps off the boat into a lifeboat, and then our United States Navy has to rescue them and save them, but they can't prosecute them for importation of drugs into the United States.

These submarines cost the drug cartels about $1 million apiece to manufacture. Intelligence sources tell us